

## Providing Culturally Sensitive Care for Transgender Patients

Shira Maguen, Jillian C. Shipherd, and Holly N. Harris, VA Boston Healthcare System, National Center for PTSD, Women's Health Sciences Division and Boston University School of Medicine

*Culturally sensitive information is crucial for providing appropriate care to any minority population. This article provides an overview of important issues to consider when working with transgender patients, including clarification of transgender terminology, diagnosis issues, identity development, and appropriate pronoun use. We also review common clinical issues for transgender individuals seeking mental health care, how these can be addressed within a CBT framework, and the process of setting up a CBT support group within a VA hospital system. CBT group outcome data and demonstrative examples from male to female transsexuals are also presented.*

PSYCHOLOGISTS RARELY RECEIVE TRAINING in transgender issues, although a wide range of information exists on how to work with transgender clients in a culturally sensitive fashion (e.g., Anderson, 1998; Carroll & Gilroy, 2002; Israel & Tarver, 1997; Lev, 2003; Lombardi, 2001; Lombardi & van Servellen, 2000; Pazos, 1999; Raj, 2002). Given the scope of issues that may be identified by transgender individuals when seeking therapy, it is important for mental health professionals to educate themselves about this population in order to provide the most clinically appropriate, sensitive and supportive care possible.

We have yet to find a transgender treatment resource specifically for cognitive behavioral therapists. Cognitive behavioral therapists are in an important position to provide interventions for transgender individuals, given that many presenting complaints will fall under the rubric of evidence-supported therapy (e.g., CBT for trauma recovery, anxiety, and depression). Further, transgender-specific issues can also be addressed within a CBT framework. Assisting transgender individuals in identifying situations, thoughts, and feelings and how these may function together, assisting with good problem-solving behaviors, and psychoeducation about transgender issues are all services that cognitive behavioral therapists can provide within a therapeutic context.

### Defining Some Crucial Terms

It should be noted that there are a multitude of terms within this community, and existing literature reviews the costs and benefits of using various transgender-related terminology (Carroll, Gilroy, & Ryan, 2002; Feinberg,

1996). Having noted this, we use the term "transgender" as an umbrella term to describe individuals that do not fit into the binary gender categories of male and female. In some ways, providing further definition for subgroups of transgender persons runs counter to the transgender all-inclusive philosophy (Boswell, 1998). However, for the newcomer to this literature, there are some subgroups within the transgender community that can be identified, including the categories we describe below, although they are not exhaustive. The definitions we include are those most commonly referred to by the transgender clients we have encountered and by existing literature (e.g., Carroll et al., 2002; Israel & Tarver, 1997). For example, "transsexuals" are individuals whose gender does not match the sex that they were assigned at birth. Transsexuals often describe feeling that they were born in the wrong body and often take gradual steps toward changing their body to better fit with their internal gender identity. Thus, these individuals are often referred to as "male to female" (MtF; also known as transgender females) or "female to male" (FtM; also known as transgender males). Transsexuals often begin hormone therapy and/or undergo a number of transformative surgeries to assist with the gender-changing process. The transition to living full-time in an identified gender is not a linear process but often a complex, intricate, and convoluted journey (e.g., Levine & Davis, 2002; Taft, 2004). Initial confusion is common and sometimes marked by periods of hyper-masculinity/femininity in a quest to fully understand gender roles (Brown & Rounsley, 2003). Many but not all transsexual individuals ultimately seek to "pass" (i.e., to be viewed by the majority of individuals as one's identified rather than assigned gender) and move toward living "full time" as their identified gender. It is culturally appropriate to refer to individuals as their self-identified gender, regardless of their appearance or level of transition (i.e., referring to a MtF individual as "she" rather than "he").

“Cross-dressing,” a term more appropriate for individuals assigned a male gender at birth, also comprises a subgroup of the transgender community. Cross-dressers, also referred to as transvestites in the past, usually live as the “opposite sex” on a part-time basis for a variety of reasons, and may or may not feel incongruence between their assigned and self-identified gender. These individuals may dress as women at home or at cross-dressing social events but otherwise live life as a male.

“Intersexuality,” formerly known as hermaphroditism, is a third subgroup of the transgender community, composed of individuals who may be born with male and female biological markers (e.g., ovaries and external male genitalia). Despite having both male and female sex characteristics, intersex individuals are usually assigned either a male or female gender at birth by family members and/or medical providers. As they grow older, their assigned gender may or may not fit with their self-identified gender.

A fourth group within the transgender community consists of individuals who feel that they fall somewhere in the middle of the gender continuum. These individuals live openly as what has been defined as “gender outlaws,” “gender queer,” and/or “gender nonconformists,” individuals who are neither male nor female, yet have the outward appearance of both (e.g., breasts and a beard). Gender nonconformists may partially transform their bodies using hormones, may recognize that they do not fit into the existing binary gender categories, and often do not identify as either male or female.

### Gender Identity Disorder as a Diagnosis

Gender Identity Disorder (GID; American Psychiatric Association, 1994) is a psychological diagnosis that describes individuals who demonstrate a cross-gender identification, a prolonged and consistent discomfort with their biological sex, and/or a desire to alter their sex characteristics. The term “gender dysphoria” is also used to describe individuals who manifest distress resulting from an incongruence of biological sex and gender identity. GID is a controversial diagnosis, as is the term gender dysphoria (see Bower, 2001; Cohen-Kettenis, 2001; Cole & Meyer, 1998). Some researchers argue that transgender individuals are a natural variation on the gender continuum and that by classifying GID in the *DSM-IV*, transgender individuals are being stigmatized in the same way that gays and lesbians were before removal of homosexuality from the *DSM-III* (e.g., Bower, 2001; Wilson, 1997). As evidence supporting this position, gender dysphoria is resolved in 87% of male-to-female and 97% of female-to-male individuals after completing sex reassignment surgery (Green & Fleming, 1990).

Given the wide range of gender identities that exist, one way to be more sensitive and recognize the diversity of gender identities is to view sex as a continuum rather

than as two dichotomous categories (e.g., Hubbard, 1998). This perspective can be viewed as a “transpositive therapeutic stance” (Raj, 2002). Indeed, there is ample evidence in biological research that there are more than two sexes. Fausto-Sterling (1993) advocated for at least five sexes in her groundbreaking article, “The Five Sexes: Why Male and Female Are Not Enough,” and has subsequently argued that in fact, there are more than five sexes when one accounts for all of the variance in sex diversity. Similarly, Eyler and Wright (1997) argue for a nine-point continuum when discussing gender. Thus, we believe that both sex and gender should be viewed as existing on continua, with gender being defined as the expression of sex.

### Transgender Identity Development

Little empirical literature exists about transgender identity development. Thus, it is unclear through which specific stages of development these individuals will pass on the way to a cohesive transgender identity. A 14-stage transgender identity developmental model has been proposed, beginning with stages marked by anxiety and confusion about gender, followed by stages of growing tolerance and acceptance, and concluding with integration and pride about transgender identity (Devor, 2004). Anecdotal evidence fits this model well; many transgender individuals go through a stage when they engage in gender-stereotyped activities that are associated with the gender to which they were assigned at birth (Brown & Rounsley, 2003). In retrospect, these individuals often report that this behavior was initiated by a futile desire to become more comfortable with their assigned gender (i.e., Identity Confusion Stage 2 and Identity Comparison: Stage 3; Devor, 2004). For example, MtF individuals may enlist in the service in the hope that the military will help “transform” them (e.g., Brown & Rounsley, 2003; Helms, 2004). As an individual moves through Devor’s (2004) proposed stages, there is a greater acceptance and identification with a transgender identity. Midway through the model, the individual will begin to identify as transgender (Identity Comparison Stage 7) and seek more information about transgender individuals (Delay Before Acceptance: Stage 8). Next, disclosure of identity begins (Acceptance of Identity: Stage 9), which will lead to garnering resources for transitioning into living as one’s identified gender (Delay Before Transition: Stage 10), followed by a formal transition (Transition: Stage 11). In the last stages, an individual lives successfully as the identified gender (Acceptance of Posttransition Gender and Sex Identities: Stage 12), learns to manage stigma and integrates various aspects of identity (Integration: Stage 13), and embraces a transgender identity, sometimes engaging in activism (Pride: Stage 14). Although the model is a heuristic for each of the stages a given individual passes through, there

are many individual variations in the quest for a cohesive transgender identity.

From our perspective at the Veterans Affairs (VA) Healthcare System, this model is particularly salient as it provides a framework for understanding why many MtFs may seek out military employment (e.g., Brown & Rounseley, 2003). Over the years there has been a noticeable presence of MtF veterans as evidenced by the development of the Transgender American Veterans Association (TAVA; founded in 2003). Unfortunately, due to the general lack of training in working with this population, there has been confusion about how to treat MtF veterans, from both a psychological and medical standpoint. It is estimated that levels of bias and misinformation are high among health care professionals and that specialized training is far less frequent with a transgender population (Carroll & Gilroy, 2002). In fact, the insensitivity of health care providers has been cited as the primary reason why transgender individuals do not access services (Sanchez, 2002). Thus, providing services such as the one we detail below can be of particular importance to transgender veterans as they pass through each stage of transgender identity development.

### Presenting Problems in Therapy

Many transgender individuals seek therapy as part of the process of transitioning from their assigned sex to their identified gender. In fact, the Harry Benjamin International Gender Dysphoria Association (HBIGDA), an organization established in 1979 to protect and advocate for the appropriate care of transgender individuals, publishes standards of care (see <http://www.hbigda.org/>). Although controversial (e.g., Meyer et al., 2001), these standards suggest that before starting hormone therapy, a preliminary step in changing gender, transgender individuals should seek therapy and/or an evaluation by a mental health professional who can write them a letter of support. Similarly, letters of support are required for gender reassignment surgery, during which a transgender individual undergoes genital transformation. Although requiring support from a mental health professional is a controversial issue, with some advocating its necessity and others feeling that it is infantilizing and insensitive (Carroll & Gilroy, 2002), it is currently a necessary part of the process for most transgender individuals who seek to alter their bodies.

Given that therapy is often suggested and/or a prerequisite for hormone therapy and surgical interventions, mental health professionals working with this population should be aware of the factors that exacerbate risk for mental health problems in transgender individuals. Transgender individuals are at risk for a range of clinical issues (Denny & Green, 1996), including but not limited to alcohol and drug use, HIV, mental health problems (e.g., de-

pression or anxiety), family conflict (or ostracism), homelessness, unemployment, and suicidality (e.g., Clements, Wilkinson, Kitano, & Marx, 1999; Nemoto, Luke, Mamo, Chiang, & Patria, 1999; Reback & Lombardi, 1999). Transgender individuals are also at high risk of discrimination, hate crimes, and physical assault, which in the worst cases result in death (e.g., Burgess, 1999; Welch & Shipherd, 2004). Lombardi, Wilchins, Priesing, and Malouf (2001) surveyed 402 transgender individuals and found that 25% experienced transgender-related violence in their lifetime. These rates are consistent with studies of the gay, lesbian, and bisexual community that examine rates of hate crimes (Herek, Gillis, & Cogan, 1999). However, a recent study found that in comparison to their gay, lesbian, and bisexual counterparts, transgender individuals are more likely to have experienced violent crimes that result in hospitalization or death (Kuehnle & Sullivan, 2001). Therefore, psychological effects of being the victim of a hate crime may also bring a transgender individual into therapy for posttrauma-related problems or posttraumatic stress disorder (PTSD).

Social isolation and a lack of overall social support are also common in transgender individuals and are barriers to increased self-esteem and self-efficacy. For example, Lombardi (1999) has demonstrated the importance of social networks in transgender individuals' lives and their effect on an individual's level of social activity. Social support is conceptualized as a crucial protective ingredient against the development of adverse mental health effects such as depression or anxiety in other populations (e.g., Goldberg, Van Natta, & Comstock, 1985; Windle, 1992; Zimet, Dahlem, Zimet, & Farley, 1988), and individuals with higher levels of social interaction have greater overall well-being (Luke, Norton, & Denbigh, 1981). Further, social support has consistently been shown to have protective qualities for trauma survivors at risk for developing PTSD (D. W. King, King, Foy, Keane, & Fairbanks, 1999; L. A. King, King, Fairbank, Keane, & Adams, 1998; Taft, Stern, King, & King, 1999). Conversely, individuals who report low social support and high distress are four times more likely to utilize medical services (Kouzis & Eaton, 1998). However, this study was not conducted with transgender individuals, and as a result the relationship between social support, distress, and service seeking among transgender individuals should be explored in future studies. Social support may serve as an important protective variable for transgender individuals that may result in decreased mental health symptoms and service utilization, especially given high rates of discrimination and victimization.

### Methods

Due to the clinical demand to provide services to MtFs in our VA hospital, a decision was made to begin an MtF

support group within the Women's Stress Disorders Treatment Team (WSDTT).

### Conceptual Framework

Given that there are no models or studies concerning group therapy for transgender individuals, our conceptualization of the group drew upon multiple theoretical approaches, but was primarily based in cognitive-behavioral theory with a focus on developing problem-solving skills in multiple domains. For example, group participants were encouraged to openly discuss situations that arose during the week and were encouraged to identify automatic thoughts and feelings associated with these transgender-related situations. For any given situation, the focus was on challenging maladaptive thoughts, problem solving (including role playing), teaching assertiveness skills (e.g., advocating for oneself with medical providers), and/or simply offering support (e.g., in cases of discrimination).

In addition to conceptualizing the group from a CBT perspective, we employed group theories (Yalom, 1995), viewing the group as a social microcosm, with each member playing a particular role within the group. We were especially attuned to individuals who adopted leadership roles within the group that tended to interfere with their own needs being met. The group also served to instill hope within group members, teach socializing techniques, highlight the importance of interpersonal relations, and serve as a corrective emotional experience (Yalom, 1995). We also conceptualized the group from a feminist theory perspective (Worell & Remer, 1992), believing that the group would ultimately serve to empower MtF veterans and give them a voice. We hoped to create an environment where the veterans would be able to trade information that would enhance their lives (e.g., information on health care, employment, housing, etc.), be challenged on issues that led to poor decision-making, and provide empowerment and support in a world where this population has often been stigmatized and silenced.

Because previous transgender group/case studies have not been conducted, our examination of outcome measures was purely exploratory in nature. We hypothesized that the group might influence social support outcomes but that depression, anxiety, and life satisfaction indices would not be changed, given that these were not explicit goals of the group.

### Procedures

We have conducted several of these groups over time, with slightly varying procedures. Specifically, we initially only included MtF transsexuals who were living full time as women, but later changed our policies to include MtF veterans at all stages of transition and other gender-questioning individuals. Also, we have experimented with varying lengths of the number of sessions ranging from 8 to 12,

but have settled on a 12-week program due to feedback by group members. Data reported in this article were collected before and after a 12-week group.

We contacted MtF veterans within the VA system through informing primary care providers, word of mouth, and posting flyers around the hospital. The group was time-limited and had a designated discussion topic each week in order to focus the conversation. Our only inclusion criterion for the group was that participants were sober from drugs and alcohol during the sessions. Before starting the group, we met individually with each potential group member to assess her needs and find out where she was in her identity development as a transgender person. We also reviewed potential topics to be covered in the group. In this individual session, we also discussed confidentiality issues, particularly as they related to documentation and each individual's phase of identity development.

The data presented below are from participating group members who provided consent to participate, following approval of the study by the VA Boston Healthcare System Institutional Review Board (IRB). Individuals completed self-report measures prior to the start of the 12-session group and understood that their group participation or treatment was in no way contingent on study participation. Posttreatment data were collected at the 12th session of the group. Although we chose to organize and present these data in the format of a traditional study, we recognize that these findings are more consistent with a case study due to the number of participants ( $n = 6$ ).

### Participants

Six Caucasian MtF transsexuals were present when data were collected pretreatment and the information presented reflect these six women's responses. The average age of group participants was 47 years ( $SD = 9.16$ ; range: 32–59 years). Three participants reported that they had served in the U.S. Navy, two had served in the Marines, and one in the Army. The average length of service was 4 years ( $SD = 1.97$ ; range: 2–6 years). Four veterans reported living in an apartment that they rented, and two were homeless. Three of the veterans were unemployed, one was disabled, one was employed part-time, and one was employed full-time. Group members had been living as women for an average of 4 years ( $SD = 2.97$ ; range <1 to 7 years). All group members began taking hormones before they began living full-time as women. Group members began hormone therapy an average of 7 years ago ( $SD = 4.03$ ; range <1 to 12 years ago). The average time between starting hormone therapy and living full-time as a woman was 3 years (range <1 to 9 years). Group members varied greatly in the types of surgeries they reported. One group member had not had any surgeries, one had facial surgery, one had tracheal surgery, one had breast surgery, one had an

orchidectomy (i.e., testicles removed), and one had full sex reassignment surgery (i.e., removal of testes, vaginal construction).

### Group Structure

The group met for 12 weeks in 60-minute sessions and was co-led by two clinicians. Each week, group began with a brief “check-in” with each group member about any transgender-related issues that were pressing. During this period, any progress on behavioral goals (described in Session 1 below) was also reported. The next agenda item was discussion of the specified topic for that week. These topics were culled collaboratively with participants from previous groups and provided a structure for each session (see Table 1). Psychoeducation was provided on the weekly topic and all participants were encouraged to discuss their experiences and consider problem-solving strategies for current issues and future plans. All participants were provided with a small, pocket-sized journal and instructed to keep track of thoughts, feelings, and questions that had arisen during the week. Many veterans used the information in their journals as a springboard to discuss weekly topics and check-in at the start of group. Group members often compared experiences and offered suggestions to others struggling with similar issues. For many participants, the group was the only forum members had to discuss and problem solve concerning transgender issues.

When veterans discussed transgender issues, they were asked to describe a specific situation, as well as their thoughts and feelings related to the particular situation. In this way, each veteran was able to receive feedback and support from both group leaders and group members. While formal thought records were not utilized, when the information shared by the veterans contained irrational thoughts, challenging questions were posed by both group leaders and other group members, which allowed veterans to reevaluate some of their automatic thoughts

about the situation. Automatic thoughts were specifically challenged by asking veterans to evaluate evidence for and against a specific belief, as appropriate. Group leaders also labeled specific dysfunctional thought patterns as they arose (e.g., “emotional reasoning” or “all-or-nothing thinking”).

After discussing the topic of the week, group leaders allowed a few minutes for closure and reintegration at the end of group (i.e., leaving the safe group environment and entering an environment that might not be as safe or supportive). During this “check-out” period, veterans also specified behavioral goals for the coming week to help them achieve their identified longer-term goals. Based on feedback from previous group participants, an individual session was also provided at the conclusion of the 12-session group for each veteran. During this session, individualized feedback concerning progress in the group was provided (e.g., goal progress, skill acquisition). In addition, we collaboratively determined future goals for each member and brainstormed about how each veteran could best use future groups to meet her needs.

### Measures

**Demographics.** We asked each individual to report age, branch of service, years in service, type of current residence, employment status, number of years living as a woman, year a hormone regimen was started, and type of surgery/surgeries received (if any). In addition, participants were asked in which areas of their lives they were currently experiencing significant difficulties, with options of housing, employment, having enough social support, sobriety from drugs and/or alcohol, anxiety and/or depression, and trauma sequelae/PTSD listed as options.

**Beck Depression Inventory (BDI).** The BDI (Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961) is a widely used self-report checklist measure of depression. Items are rated on a 4-point Likert scale, based on depressive symptoms over the past week. Responses to each item are added for a total score of global depression, with higher scores indicating more depression. This measure was included to track fluctuations in mood that occurred over the course of the group and also to monitor suicidal ideation in this at-risk population (Carroll, 1999).

**State and Trait Anxiety Inventory.** This scale contains 20 items assessing state anxiety (transitory; STAI-S) and 20 items assessing trait anxiety (chronic; STAI-T), rated on a 4-point Likert scale (Spielberger, Gorsuch, & Lushene, 1970). Half of the items on these measures are reversed scored and then a total is generated to determine anxiety levels, with higher scores reflecting more anxiety. Both the STAI-S and STAI-T were administered to evaluate if anxiety levels could be influenced by the cognitive and behavioral changes encouraged during treatment.

**Network Orientation Scale (NOS).** This scale includes 20

**Table 1**  
Sample Group Topics for a 12-Week Group

Week 1	Introductions, ground rules, confidentiality
Week 2:	Childhood, identity, and development
Week 3:	Military service and young adulthood
Week 4:	Personal safety (e.g., drug and alcohol use, HIV risk, hormone injection)
Week 5:	Employment
Week 6:	Housing
Week 7:	Social support
Week 8:	Family issues and parenting
Week 9:	Medical issues (e.g., hormone maintenance, surgeries, and health care)
Week 10:	Disclosure, passing, and socialization
Week 11:	Body issues and intimate relationships
Week 12:	Closure

items designed to assess propensity to utilize social support networks in times of need (Vaux, Burda, & Stewart, 1986). All items are rated on a 4-point Likert scale and half the items are reverse scored. A total score is generated with higher scores indicating a positive network orientation. This measure was included to evaluate whether the proclivity to utilize social support networks increases following group attendance.

*Life Satisfaction Index (LSI).* This scale consists of 18 items that are designed to assess degree of adjustment and satisfaction with current life circumstances (Neugarten, Havighurst, & Tobin, 1961). Patients can rate that they "agree," "disagree" or are "unsure" for each of the statements. Weights are assigned to each of the responses for each item. These weights are then summed to determine overall score on this measure, with higher scores indicating greater life satisfaction. This measure is typically used in the assessment of older adults because the measure compares current life satisfaction with previous performance in this area (e.g., I am just as happy as when I was younger). Thus, this measure was determined to be appropriate for the current population; each participant was asked to compare her life now to her life prior to acknowledging her transgender identity.

## Results

### Demographic Data

At pretreatment, 67% of participants reported problems with housing ( $n = 4$ ), 67% reported problems with employment ( $n = 4$ ), and 67% reported not having enough psychosocial support ( $n = 4$ ). Additionally, 34% of group members reported struggling to maintain sobriety from alcohol and drugs ( $n = 2$ ), 67% reported problems with anxiety and/or depression ( $n = 4$ ), and 67% reported significant trauma histories and problems with PTSD symptoms ( $n = 4$ ).

### Pre-Post Self-Report Data

Psychosocial results are presented for each of the five measures administered before and after group. Intra-individual change scores were not calculated given that there were only two data points per group participant. Overall, women in the group demonstrated improvement on measures of anxiety and depression from pre- to posttreatment, despite the fact that these symptoms were not specifically targeted for treatment in the group. One possibility is that individuals were able to use skills learned in the group to challenge maladaptive thoughts that also triggered depression and anxiety symptoms. Four of the six participants reported increases in their social support from pre- to posttreatment. However, life satisfaction indices decreased for the majority of participants over the course of treatment, perhaps due to the multitude of life

**Table 2**  
Scores for Measures Pre- and Post-Group

Name	BDI		State		Trait		NOS		LSI	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
A	4	3	30	20	32	33	2.5	2.5	33	26
B	23	11	70	55	65	50	2.5	3.0	12	10
C	1	6	29	3	37	32	2.5	2.2	28	26
D	4	9	38	35	39	38	2.2	2.7	20	19
E	32	23	68	56	62	56	2.8	2.9	2	4
F	36	30	51	62	46	59	2.7	4.9	8	9

*Note* NOS = Network Orientation Scale; LSI = Life Satisfaction Index.

changes, including becoming unemployed and homeless, that occurred for several group participants throughout the course of the group (see Table 2).

### Qualitative Data by Session

Participants have provided their consent for inclusion of these illustrative examples through procedures reviewed by the IRB, and we describe these scenarios in general terms in order to fully protect our group members' identities. These are topics that apply to both group therapy and individual therapy with MtF transgender individuals.

### Pretreatment Appointments: Confidentiality, Goal Setting, and Information

The VA system is one in which records are centrally computerized and, as a result, any health care provider can have access to an individual's therapy notes. We did not want to unnecessarily "out" an individual (i.e., document that she was transgender without the given individual deciding to disclose her transgender identity to other providers). As a result, documentation was openly discussed during individual meetings prior to the start of group. Each group member with whom we met preferred that we use the pronoun "she" in the notes. Upon consulting with our group members, we also collaboratively decided to call the group the "women's identity group," rather than the transgender identity group. We wanted to respect each individual's confidentiality in the same way that we would not want to "out" individuals who were gay or lesbian. Unfortunately, we have found that other health care providers within the VA system have not been as mindful in their documentation. We advocate for protecting the confidentiality of sensitive information regarding gender identity and discussing this issue with each client in advance of documenting sessions.

Goal setting was another topic covered in this individual session. Group members were asked to choose up to three goals that could be operationally defined and were achievable within the time frame of the group (e.g., finding housing, scheduling a medical appointment, engaging in specific self-care activities). Participants kept track

of these goals in their journals and progress concerning each of these goals was monitored on a weekly basis during the check-in phase of the group sessions. Each week, group members were reinforced for moving forward with these goals and received assistance with their problem-solving efforts if they were unable to make progress.

During the pre-group meetings “fact sheet” handouts were provided to group participants who were seeking information on specific topics (e.g., step-by-step guide on how to legally change your name, local transgender-friendly shopping, information and resources for a number of surgeries, information about hormone therapy, etc.). These fact sheets were used for educational purposes and were especially helpful for those who were early in the transitioning process. This early psychoeducational intervention was designed to create an atmosphere of trust and open exchange regarding information that can be difficult to talk about. Using these fact sheets, it was possible to challenge irrational beliefs about these issues and provide corrective information within a CBT framework. Finally, during these initial individual sessions, the rule of sobriety during group sessions was explained and discussed as it applied to each participant.

#### **Session 1: Confidentiality, Introductions, and Group Rules**

During the first group session, confidentiality was reviewed. Participants were able to meet one another, discuss expectations and concerns regarding group participation, and detail their behavioral goals for the group.

#### **Session 2: Childhood, Identity, and Development**

This early session has assisted in creating bonds among group participants. Specifically, hearing that other transgender individuals struggled with similar gender issues in childhood and also felt alienated and confused during adolescence is extremely empowering and affirming for many of our group members. Given that adolescence is a difficult developmental period for most individuals, transgender individuals must negotiate a host of additional issues related to their gender identity development, which may cause them to feel even more alienated from their peers (Brown & Rounsley, 2003; Israel & Tarver, 1997). Growing up in a world in which gender is dichotomized creates a confusing backdrop for most transgender individuals, especially given the scarcity of role models in this domain. Most transgender individuals in our group described knowing that they were different during adolescence, and even in early childhood (e.g., remembered creating games in which they got to be female), but not being able to label their experience until many years later. Due to feelings of being different, most group members described being “loners” and lacking close friends during the period where the peer group becomes a central facet

of development for most adolescents. It is during this time that veterans may develop certain core beliefs about these experiences. As a result, during this group we probe for specific thoughts or beliefs about the self that may have become ingrained and need to be challenged (e.g., “Because I am different, no one will want to be close to me” or “if others don’t approve of me, I may not be worthy”).

#### **Session 3: Military Service and Young Adulthood**

For our veterans, early adulthood was a time during which many enrolled in the military, hoping that this hypermasculine environment would help “set them straight” and facilitate adoption of a male gender identity. For many, the military was a disappointment due to the realization over time that their gender identity could not be changed. While many veterans reported playing a hypermasculine role in order to fit in and be accepted by the group, others reported severe ridicule, and in the worst case, military sexual trauma (i.e., being raped by fellow soldiers). Most described “living a lie” during this period (i.e., pretending to be someone who they were not in order to get through their enlistment). For many, the military was the final confirmation that they were transgender and that this was an immutable identity.

#### **Session 4: Personal Safety**

Personal safety of group members was discussed on multiple levels. Physical safety was important due to the high rates of violence perpetrated against transgender people (e.g., Lombardi et al., 2001). During this group, members are reminded of these high rates and encouraged to brainstorm about strategies to reduce personal risk (e.g., not traveling alone late at night, carrying a cell phone). We also discuss sexual communication, sexual safety (e.g., using condoms, high-risk partners), and HIV prevention/transmission (e.g., not sharing needles). Some of the group members had multiple risk factors for HIV (e.g., sex work, drug use) and as a result, we discussed the importance of being tested for HIV. Substance abuse was also covered during this session, especially given that reduction of alcohol use was a goal for some group members.

#### **Session 5: Employment**

As our demographic data demonstrate, many individuals in the group alternated between having a job and being unemployed. Most group participants had to contend with a great deal of discrimination, especially when living full-time as women but not passing easily. As described by our group participants, discrimination was both overt (i.e., being told not to use the public restrooms) and covert (i.e., coworkers talking behind an individual’s back). Often, the majority of an individual’s employment history had been experienced as a male. As a result, asking for recommendations from past employers

or describing past jobs that may be more male dominated (e.g., construction) became complicated, sometimes necessitating disclosure of transgender status. Furthermore, a few group participants had transitioned from living full-time as male to female while employed. This caused a great deal of confusion for other workers, and in one situation resulted in the veteran teaching coworkers about what it meant to be transgender. In other cases, it meant losing a job. It was also difficult for our group members to determine if they were fired for valid reasons or due to discrimination when the stated reasons were vague, such as "you were not living up to our standards." Securing a new job became particularly challenging for individuals who did not pass well as women. Because of the multiple levels of reality-based discrimination, bias, and transphobia that group members experienced, many became discouraged when seeking employment. As a result, the group served as an important safe haven to challenge maladaptive thoughts (e.g., "I can't get a good job because I am transgender") and assist with problem-solving skills concerning seeking transgender-friendly employment.

#### **Week 6: Housing**

In our sample, five of the six participants had been homeless at one point in their lives. In some cases, homelessness was temporary and occurred after disclosure to a spouse or family member. In other cases, homelessness was a chronic problem, and reportedly compounded by discrimination by potential landlords. Group members reported housing discrimination ranging from subtle (i.e., not returning phone calls or e-mails after disclosure) to more direct (e.g., "We don't have a room for people like you"). An important part of this group is acknowledging that discrimination exists while at the same time challenging dysfunctional thoughts that prevent group members from seeking or finding adequate housing. Shared transgender-friendly housing resources was also an important component of this group. For example, when one veteran was homeless and struggling to find a place to live, other group members shared information about the relative merits and problems of the local shelters with regard to gender sensitivity.

#### **Week 7: Social Support**

A lack of social support was a commonly discussed problem, and group members generally used the group as a way to connect with other transgender veterans and expand social support networks. While a discussion of existing support was important, the group also focused on thoughts and beliefs that prevented group members from expanding their social networks (e.g., fear of rejection and overgeneralization about the attitudes of others toward transgender individuals). When consistent with specified objectives, group members were encouraged to

set goals concerning reaching out to others and expanding support systems.

#### **Week 8: Family Issues and Parenting**

Family issues were always an important yet avoided group topic among our members. Similar to gay, lesbian, and bisexual individuals, many transgender individuals were disowned or cut off from their families after a transgender identity was disclosed. The majority of group members were no longer speaking to their parents and in rare cases spoke with siblings. This resulted in having to re-create families who accepted them and their transgender status, often consisting mainly of friends. Most of the group members struggled with this situation, and wished that their families could accept their current identity. In our experience, this caused fluctuating relationships with the biological family over time, but usually resulted in disappointment and a return to the re-created family. For example, one group member who had been living full time as a woman for many years was not allowed to have contact with her brother and his children because the brother feared that the veteran would confuse his children. Desperately wanting to have contact with her family, the veteran considered dressing as a man to go visit her brother and his family. After identifying automatic thoughts and feelings associated with this specific situation, group leaders and group members were able to offer support but also challenge some of the veteran's core beliefs about herself and who she needed to be to have a relationship with her family. Ultimately, she decided that dressing as a man to appease her brother would be denying and falsely representing her true identity, something she had worked hard to overcome. Other group members struggled with religious parents who they feared would never understand or accept their true identity. Family issues were also complicated when group members had been married to women prior to transitioning and had children or even grandchildren who knew them in their male identities. Oftentimes the veterans felt conflicted about having contact with their younger children or young grandchildren whom they feared they would "confuse." In some cases, older children had chosen not to have contact with the veteran for a variety of reasons, which was a significant loss. Other veterans who were at earlier points of transition and were not living full-time as women struggled with disclosure to family members and the best way to tell loved ones about their transgender identity. In this situation, role-playing these interactions in the group offered an opportunity for practice and corrective feedback. Anecdotal stories from other group members also allowed for the opportunity to decatastrophize and challenge all-or-nothing thinking (e.g., moving from "my family will never accept me" to "they may have a hard time at first but they will still love me"). Each of

the family issues described above offered opportunities to challenge maladaptive thoughts, teach problem-solving skills, and role-play difficult family situations.

#### **Week 9: Medical Issues (e.g., Hormone Maintenance, Surgeries, and Health Care)**

The group was an important forum for individuals to discuss different aspects of medical care and share information about providers who had been sensitive to their needs. Similar to many mental health providers, the majority of medical providers do not receive training concerning how to treat transgender individuals (e.g., Israel & Tarver, 1997). Due to both the ambivalence group members felt about their bodies and the lack of training for medical providers, seeking health care was an uncomfortable experience for our group participants. As a result, many transgender individuals in the group avoided routine medical care. Further complicating this situation, several group participants were interested in a variety of medical procedures to transform their bodies, ranging from electrolysis to sex reassignment surgeries (i.e., genital surgery). Due to the intricacies and complexities of these surgeries, comprehensive medical care was essential. Our group benefited from the ability to share information about their experiences and provide advice to one another. For example, when one group member was seeking gender reassignment surgery, others offered advice concerning surgeons and follow-up aftercare from research they had conducted and word-of-mouth in the transgender community. Additionally, all group participants were provided with an opportunity to role-play in order to practice advocating for themselves with medical providers. Through this role-playing activity, group members were able to make suggestions and challenge maladaptive beliefs (e.g., "I don't deserve specialized care because I am transgender" or "I am not going to be taken seriously, so why bother").

#### **Week 10: Disclosure, Passing, and Socialization**

Level of disclosure of transgender identity varied among group participants, with some disclosing to only a few select friends/family, and others disclosing to the majority of loved ones and friends. Individuals used the group as an arena to problem solve and receive coaching about whom to tell, under what circumstances, and how to disclose. One example was a group member who wanted to tell her two older sons, to whom she felt close, before beginning her transition into living full-time as a woman. The group was used as a forum to practice and receive feedback about this disclosure as well as to challenge dysfunctional thoughts that prevented her from disclosing (e.g., "They will never really be able to accept the real me"). The interaction between passing and disclosure was also important to our group participants. Those who

passed well as women (i.e., passed for being a woman in a variety of circumstances) felt more fear about disclosing to others (e.g., "Everyone thinks I am a woman, so why bother telling others?") than those who felt that they were not as likely to pass as women ("I might as well explain myself since they will know that I am not a genetic female"). The benefits and barriers to disclosure (e.g., Maguen et al., 2005) were reviewed in this context, and the group assisted each member in making a decision that was best for her situation.

Socialization was a crucial topic to discuss, given that our group participants had all been raised as men and in a military culture. For example, during the course of the group, some members commented on "feeling weak" for displaying varying degrees of sadness. While it was important to challenge this dysfunctional thought, the role of socialization was especially crucial to highlight in this scenario and in the context of describing the connection between thoughts and emotions.

Another common topic with respect to socialization into a new gender role is the issue of emotional closeness in friendships. For example, one group member expressed confusion about a female friend who frequently touched the veteran. Through psychoeducation about the nature of female friendships and by challenging dysfunctional thoughts concerning this relationship, the veteran came to understand that these gestures were expressed within the context of a friendship, rather than as signs of interest in a romantic relationship.

#### **Week 11: Body Issues and Intimate Relationships**

Among our group participants, some had romantic relationships either as men or as women with varying levels of success, while others had never had romantic and/or sexual relationships. During this session, group members were asked to think about what they were looking for in a partner. For at least one group participant, this was the first time she had considered which qualities she might find desirable, and her first response to this question was "anyone who will accept me." One of the goals of the group was to empower group members to believe that they have a choice over whom they seek as a partner. All of our group members reported some level of discouragement because they had bad experiences with dating, especially when they were trying to avoid disclosing their transgender identity. Therefore, when and how to disclose transgender status was often discussed. General levels of dissatisfaction and discouragement with dating situations were also normalized, and participants were also encouraged to consider that these feelings are also common for genetic females.

Body image is a confounding factor as well, and an important aspect of this session is challenging unrealistic expectations of what they hope their bodies will look like in

the future (i.e., challenging notions of a “perfectly” female body). Another goal was working toward acceptance of their bodies in their current form, regardless of how it “fits” or does not fit into the stereotypical female body (e.g., coming to accept a larger frame size, bigger hands, etc.).

### **Week 12: Closure**

While goals were tracked each week, in the final week a summary of progress was reported by each group member, and a list of maintenance goals or new goals were set for the coming weeks. The last session was also used to summarize what group members learned with respect to understanding the connection between their thoughts and feelings. We also reviewed specific thought-challenging strategies and problem-solving skills that had been used throughout the group. Group members were encouraged to use the skills they learned and were given the chance to provide feedback to other group members or to group leaders within the context of the group. In the last part of group, members were asked to complete psychometric measures so that leaders could track improvements of each group member. Finally, individualized feedback sessions were scheduled in order to provide more specific feedback and to allow time for treatment planning specific to each group participant’s needs.

### **Challenges Faced Implementing the Group**

During the group, each member took on a specific role. For example, one group member who had been living as a woman for nearly a decade and “passed” well served as a role model in some domains, providing useful information. While she served an important function in the group, it was also important to challenge her to discuss some of her own issues in relation to being transgender so she too would be able to access support from group members. Another issue that arose in the group was consistency of attendance. Our MtF veteran population struggled with socioeconomic issues of employment and homelessness (due to issues of bias, discrimination, and comorbidity), and many group members’ employment status fluctuated during the course of the group, which made attendance difficult. Homelessness and living far from the VA were also issues that affected attendance. During the course of the group, one member moved out of state and was not able to make group meetings. Many of our group members also lived in nearby states or outside of the metropolitan area, and traveled many hours to attend group, which further highlights the need for more transgender-related services.

### **Discussion**

While we believe that increasing cultural sensitivity with respect to transgender individuals is important for

all therapists, given that seeking mental health care is often required in order for transgender individuals to receive medical care that assists them in leading a gender-congruent life (e.g., seeking hormones, surgeries), we argue that CBT therapists are in a unique position to assist transgender individuals. More specifically, CBT therapists are trained to provide evidence-based interventions that can assist transgender individuals with many presenting problems (e.g., CBT for depression), and the majority of transgender-specific issues can be addressed within a CBT framework (e.g., challenging maladaptive thoughts about being transgender). We hope that the description of our group can serve as a roadmap for both group and individual therapy, and we have made an attempt to highlight some important areas for intervention within a predominantly CBT framework.

Transgender individuals face a number of challenges on their journey to living as their self-identified gender. The establishment of a transgender support group is one way to create a safe environment for individuals struggling to consolidate their gender identity. Group therapy for these individuals also reduces isolation and allows transgender experiences to be mirrored and validated by similar others. We utilized a cognitive-behavioral framework as the backbone of our group, employing techniques such as challenging maladaptive thoughts and encouraging active problem solving, especially involving issues of social support and affiliation. A common cognitive style among our group participants was catastrophic thinking, which had been compounded by repeated experiences with discrimination. Core beliefs also required some modification, given that none of our group members felt they had received acceptance on a societal level, which exacerbated existing negative self-images. Problem-solving skills were also an important area of intervention. Our veterans reported that these strategies were particularly useful when advocating for care in medical settings and when struggling with family or employment issues. The use of role-plays, modeling, and providing constructive feedback was reportedly helpful, especially in the preliminary phases of transition when individuals wished to practice disclosing their transgender identities to family members, friends, or coworkers. The power of basic psycho-education and “fact sheets” in this population should not be underestimated. Our veterans stated that this information was helpful in a number of domains ranging from the basics of establishing a transgender identity (e.g., legal name change) to information about preparing for medical procedures and engaging in safety behaviors (e.g., minimizing HIV risk). Further, the veterans reported that the regular “check-ins” were assistive in motivating behavioral changes they had identified.

Group and feminist theories were also helpful and have allowed us to understand each individual’s role

within the social microcosm of the group as well as the importance of empowerment within a population that experiences chronic discrimination. When instituting this support group, we sought to provide a safe, supportive, and judgment-free environment, in which veterans could openly explore issues related to being transgender, and receive support and validation from others who had experienced similar struggles. According to Devor (2004), these processes of "witnessing and mirroring" are the foundation for transgender identity formation. More specifically, transgender individuals need to be accurately witnessed and mirrored in the eyes of others in a way that is consistent with an individual's own self-perception. Devor (2004) argues that in addition to being mirrored by those that are different, transgender individuals also need to be validated by those who are similar. We found that the majority of transgender veterans that we encountered had not previously participated in a group format with similar peers, and that several had little previous face-to-face contact with other transgender individuals (although some had participated in on-line chat groups). For many group members, simply being in such an environment seemed to reduce transgender-related isolation and stigma. Having this group in an environment such as the VA healthcare system also felt supportive to the veterans who had conceptualized being rejected at a systemic level (e.g., by a government organization). We hoped to facilitate creation of a social support environment within the group, given its importance in transgender individuals' lives (Lombardi, 1999). Additionally, we hoped to assist individuals' access to support in their communities and to send the message that support can be found in places that each veteran might least expect.

In an effort to quantify the benefits of the support group, we attempted to gather some data from our group participants. Measurement selection was difficult as there are no measures specifically designed to measure the psycho-social impact of a transgender support group. Given these limitations, it is clear that individuals from our group struggled with a number of transgender-related problems, such as employment, housing, and lack of social support. Furthermore, individuals' depression and anxiety scores seemed to decrease, and a propensity to utilize social support networks increased following group participation, trends that should continue to be investigated in future studies. Life satisfaction indices decreased for the majority of participants, possibly due to life changes such as becoming unemployed and homeless. Future studies should strive to employ a larger sample of transgender individuals that are ethnically diverse and follow these individuals for longer periods of time so that firmer conclusions can be drawn from outcome data, and longitudinal effects of the support group can be assessed. Future studies may also want to include measures of stigma, empower-

ment, and social isolation to explore whether group treatment influences any of these variables. Ideally, psychometrically sound measures that tap relevant constructs will be developed.

In this article, we have tried to provide a brief snapshot of the transgender individuals with whom we have had contact, their unique issues, the development of the group, and examples specific to working with this population. Overall, it is clear that we as providers have merely begun to understand the unique issues faced by this group and how to help transgender individuals in the most respectful way possible. Providing sensitive care is necessarily a collaborative process that is in the beginning of its evolution. The more providers can be aware of the elements of sensitive care, involving transgender patients in this process, the more we can move towards providing treatment that promotes amelioration of transgender-related problems, education, support, and empowerment.

## References

American Psychiatric Association. (1994). *Diagnostic and statistic manual of mental disorders* (4th ed.). Washington, DC: Author.

Anderson, B. F. (1998). Therapeutic issues when working with transgender clients. In D. Denny (Ed.), *Current concepts in transgender identity* (pp. 215-226). New York: Garland Publishing.

Beck, A. T., Ward, C. H., Mendelsohn, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of general psychiatry*, 4, 561-571.

Boswell, H. (1998). The transgender paradigm: Shift toward free expression. In D. Denny (Ed.), *Current concepts in transgender identity* (pp. 55-61). New York: Garland Publishing.

Bower, H. (2001). The gender identity disorder in the DSM-IV classification: A critical evaluation. *Australian and New Zealand Journal of Psychiatry*, 35, 1-8.

Brown, M. L., & Rounsley, C. A. (2003). *True selves: Understanding transsexualism*. San Francisco: Josey-Bass.

Burgess, C. (1999). Internal and external stress factors associated with the identity development of transgender youth. *Journal of Gay and Lesbian Social Services*, 10, 35-47.

Carroll, L., & Gilroy, P. J. (2002). Transgender issues in counselor preparation. *Counselor Education and Supervision*, 41, 233-242.

Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Counseling transgender, transsexual, and gender-variant clients. *Journal of Counseling and Development*, 80, 131-139.

Clements, K., Wilkinson, W., Kitano, K., & Marx R. (1999) HIV Prevention and health service needs of the transgender community in San Francisco. *International Journal of Transgenderism*, 3. Retrieved September 20, 2005, from [http://www.symposion.com/jt/hiv\\_risk/clements.htm](http://www.symposion.com/jt/hiv_risk/clements.htm)

Cohen-Kettenis, P. T. (2001). Gender identity disorder in DSM? *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 391.

Cole, C. M., & Meyer, W. J. (1998). Transgender behavior and the DSM-IV. In D. Denny (Ed.), *Current concepts in transgender identity* (pp. 227-236). New York: Garland.

Denny, D., & Green, J. (1996). Gender identity and bisexuality. In B. Firestein (Ed.), *Bisexuality: The psychology and politics of an invisible minority* (pp. 84-102). Thousand Oaks, CA: Sage.

Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model of transsexual identity formation. *Journal of Gay and Lesbian Psychotherapy*, 8, 41-67.

Eyler, A. E., & Wright, K. (1997). Gender identification and sexual orientation among genetic females with gender-blended self-perception: Childhood and adolescence. Retrieved October 25, 2005, from <http://www.symposion.com/jt/jtc0102.htm>

Fausto-Sterling, A (1993) The five sexes Why male and female are not enough. *The Sciences, March/April*, 20–25.

Fernberg, L (1996) *Transgender warriors*. Boston: Beacon Press.

Goldberg, E L, Van Natta, P, Comstock, G W (1985) Depressive symptoms, social networks and social support of elderly women. *American Journal of Epidemiology*, 121, 448–456.

Green, R, & Fleming, D T (1990) Transsexual surgery follow-up: Status in the 1990s. *Annual Review of Sex Research*, 1, 163–174.

Helms, M. F (2004) Mission accomplished. *Transgender Tapestry*, 107, 32–35.

Herek, G M, Gillis, J R, & Cogan, J C (1999) Psychological sequelae of hate-crime victimization among lesbian, gay, and bisexual adults. *Journal of Consulting and Clinical Psychology*, 67, 945–951.

Hubbard, R (1998) Gender and genitals: Constructs of sex and gender. In D Denny (Ed.), *Current concepts in transgender identity* (pp 45–54). New York: Garland Publishing.

Israel, G E, & Tarver, D E (1997) *Transgender care: Recommended guidelines, practical information, and personal accounts*. Philadelphia: Temple University Press.

King, D W, King, L A, Foy, D W, Keane, T M, & Fairbank, J A (1999) Posttraumatic stress disorder in a national sample of female and male Vietnam veterans: Risk factors, war-zone stressors, and resilience-recovery variables. *Journal of Abnormal Psychology*, 108, 164–170.

King, L A, King, D W, Fairbank, J A, Keane, T M, & Adams, G A (1998) Resilience-recovery factors in post-traumatic stress disorder among female and male Vietnam veterans: Hardiness, post-war social support, and additional stressful life events. *Journal of Personality and Social Psychology*, 74, 420–434.

Kouzis, A C, & Eaton, W. W (1998). Absence of social networks, social support, and health service utilization. *Psychological Medicine*, 28, 1301–1310.

Kuehnle, K, & Sullivan, A (2001). Patterns of anti-gay violence: An analysis of incident characteristics and victim reporting. *Journal of Interpersonal Violence*, 16, 928–943.

Lev, A. I (2003) *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: Haworth Press.

Levine, S B, & Davis, L (2002) What I did for love: Temporary returns to the male gender role. *International Journal of Transgenderism*, 6(4). Retrieved September 20, 2005, from [http://www.symposion.com/ijt/ijtvo06no04\\_04.htm](http://www.symposion.com/ijt/ijtvo06no04_04.htm)

Lombardi, E L (1999) Integration within a transgender social network and its effect upon members' social and political activity. *Journal of Homosexuality*, 37, 109–126.

Lombardi, E. L (2001) Enhancing transgender health care. *American Journal of Public Health*, 91, 869–872.

Lombardi, E. L, & van Servellen, G (2000) Building culturally sensitive substance use prevention and treatment programs for transgender populations. *Journal of Substance Abuse Treatment*, 19, 291–296.

Lombardi, E L, Wilchins, R A, Priesing, D, & Malouf, D (2001) Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality*, 42, 89–101.

Luke, E, Norton, W, & Denbigh, K (1981) Medical and social factors associated with psychological distress in a sample of community aged. *Canadian Journal of Psychiatry*, 26, 244–250.

Maguen, S, Shipherd, J C, Harris, H N, & Welch, L P (2005) *Prevalence and predictors of disclosure of transgender identity*. Manuscript submitted for publication.

Meyer, W, Bockting, W, Cohen-Kettenis, P T, Coleman, E, DiCeglie, D, Devor, H, Gooren, L, Joris Hage, J, Kirk, S, Kuiper, B, Laub, D, Lawrence, A, Menard, Y, Patton, J, Schaefer, L, Webb, B, & Wheeler, C (2001). Harry Benjamin international gender dysphoria association's standards of care for gender identity disorders—Sixth version. Retrieved October 25, 2005, from [http://www.symposion.com/ijt/soc\\_2001/index.htm](http://www.symposion.com/ijt/soc_2001/index.htm)

Nemoto, T, Luke, D, Mamo, L, Chiang, A, & Patria, J (1999). HIV risk behaviors among male-to-female transgenders in comparison with homosexual or bisexual males and heterosexual females. *AIDS Care*, 11, 297–312.

Neugarten, B L, Havighurst, R J, & Tobin, S S (1961) The measurement of life satisfaction. *Journal of Gerontology*, 16, 134–143.

Pazos, S (1999) Practice with female-to-male transgender youth. *Journal of Gay and Lesbian Social Services*, 10, 65–82.

Raj, R (2002) Towards a transpositive therapeutic model: Developing clinical sensitivity and cultural competence in the effective support of transsexual and transgender clients. *International Journal of Transgenderism*, 6. Retrieved September 20, 2005, from [http://www.symposion.com/ijt/ijtvo06no02\\_04.htm](http://www.symposion.com/ijt/ijtvo06no02_04.htm)

Reback C J, & Lombardi, E L (1999). HIV Risk Behaviors of Male-to-Female Transgenders in a Community-based Harm Reduction Program. *International Journal of Transgenderism*, 3. Retrieved September 20, 2005, from [http://www.symposion.com/ijt/hiv\\_risk/reback.htm](http://www.symposion.com/ijt/hiv_risk/reback.htm)

Sanchez, D (2002) *Giving healthcare to transgender patients*. Boston: JRI Health, Transhealth & Education Development.

Spielberger, C D, Gorsuch, R. L, & Lushene, R D (1970) *Manual for the State-Trait Anxiety Inventory (self-evaluation questionnaire)*. Palo Alto, CA: Consulting Psychologists Press.

Taft, C T, Stern, A. S., King, L A, & King, D W (1999) Modeling physical health and functional health status: The role of combat exposure, posttraumatic stress disorder and personal resource attributes. *Journal of Traumatic Stress*, 12, 3–23.

Taft, L A W (2004). The long and winding road to social acceptance. *Transgender Tapestry*, 107, 15.

Vaux, A, Burda, P, Jr, & Stewart, D (1986) Orientation towards utilizing support resources. *Journal of Community Psychology*, 14, 159–170.

Welch, L P, & Shipherd, J. C. (2004, November) *Rates of violence and sexual orientation in the transgender community*. Poster presentation at the annual meeting of the Association for Advancement of Behavior Therapy, New Orleans, LA.

Wilson, K (1997) *Gender as illness: Issues of psychiatric classification*. Presented at the sixth annual International Conference on Transgender Law and Employment Policy (ICTLEP), Houston, Texas.

Windle, M (1992) A longitudinal study of stress buffering for adolescent problem behaviors. *Developmental Psychology*, 28, 522–530.

Worell, J, & Remer, P (1992) *Feminist perspectives in therapy: An empowerment model for women*. New York: Wiley.

Yalom, I D (1995) *The theory and practice of group psychotherapy*. New York: Basic Books.

Zimet, G D, Dahlem, N W, Zimet, S G, & Farley, G. K. (1988) The multidimensional scale of perceived social support. *Journal of Personality Assessment*, 52, 30–41.

Shira Maguen is now at the San Francisco VA Medical Center.

The authors would like to thank the members of the support group for their willingness to share their experiences in this publication. In addition, we would like to thank Lisa Welch for her assistance in preparing this manuscript. We would like to note that these data were presented in part at the Association for Advancement of Behavior Therapy's 37th annual convention.

Address correspondence to Dr Shira Maguen, San Francisco VA Medical Center, PTSD Program (116P), 4150 Clement St., Building 8, Room 206, San Francisco, CA 94121, e-mail: shira.maguen@va.gov

Received: August 19, 2004

Accepted: May 12, 2005